SERVICE IMPROVEMENT OPTIONS

Please Note
The sequence in which items are presented is not meant to imply a priority order.

For Review and Prioritization

by the

Joint Legislative and Executive Task Force
On
Mental Health Service Delivery and Financing

REVISED 11/1/2004

Service Improvement Option #1
EXPEDITE MEDICAID ENROLLMENT FOR "STATE-ONLY" CLIENTS

Strategy: Pursue strategies to expedite Medicaid enrollment for clients whose mental health treatment has generally been 100% state funded.

Description: There are a variety of reasons why some mental health system clients who appear to be Medicaid eligible are not actually enrolled as Medicaid clients. This includes individuals recently released from jails, prisons, and the state hospitals. It also includes clients whose disability interferes with their ability to go to the local CSO to apply and/or their ability to consistently follow through on the lengthy federal SSI disability approval process. In addition, more low-income "state-only" clients who are employed may be eligible for Medicaid through "Medicaid Buy-in".

This option would facilitate the Medicaid enrollment or reinstatement process for clients whose mental health care would otherwise be 100% state-funded. Strategies include:

1) Assigning SSI/CSO eligibility workers to a circuit of jails, prisons, and state hospitals, as well as community mental health facilities. These workers would facilitate the Medicaid reinstatement or enrollment process as appropriate for individuals who are SSI-disabled or who appear to meet federal SSI disability standards.
2) Stationing DASA and Home and Community Services (HCS) workers in the state hospitals to expedite application and eligibility for community based services.
3) Launching additional outreach efforts to educate RSNs and providers about the Healthcare for Workers with Disabilities Program ("Medicaid Buy-in").

Projected Net Impact in State Dollars: Savings of ($716,000) per year

Anticipated Outcomes of Approach:
By securing Medicaid enrollment for eligible mental health clients, the state will reduce its cost for treating these clients by approximately half. While these clients may then receive more outpatient treatment than they would have as "state-only" clients, it may also lead to greater stabilization and less need for costly ITA evaluations, crisis services, and/or psychiatric hospitalizations. Mental Health Division service data demonstrates that those non-Medicaid clients that received crisis only services in FY03 were far more likely to need an ITA evaluation than were Medicaid clients.

Possible Disadvantages, or Implementation Barriers:
While at least one CSO currently has outreach workers who visit local jails to facilitate Medicaid reinstatement for SSI-disabled inmates upon release (and do so quite successfully), this could be a culture change for other CSO offices and their eligibility determination workers. And, while feedback from local law enforcement on this concept has been positive, effective implementation will require careful interagency coordination.

Service Improvement Option #2
HIGH-INTENSITY TREATMENT FOR ADULTS

Strategy: Develop PACT/ACT high intensity treatment teams throughout the state for adults who are high utilizers of mental health services.

Description: Create 18 treatment teams, based on the PACT/ACT "Evidence Based Practice" model, to treat adults with serious and persistent mental illness in a comprehensive, locally based way. PACT/ACT teams have been shown to pay for themselves by decreasing use of acute inpatient treatment both in this state and in many others.

The treatment teams (with staff to client ratios of 1:10) would be targeted to those individuals experiencing significant disabilities from mental illness where traditional outpatient models (with staff to client ratios of 1:60) have not been successful at preventing severe acute episodes. In total, the teams would serve a caseload of 1008 clients at any given time.

Teams focus on: 1) lessening or eliminating those symptoms of mental illness that are debilitating to the client; 2) preventing or minimizing acute psychiatric episodes; and 3) improving functioning enough to allow employment and/or independent living. This multi-faceted approach is designed to enhance the quality of life of the client and his or her family members.

Projected Net Impact in State Dollars: Cost of $3.4 million per year (3-yr average)

Cost notes: Savings due to reduced community and state hospital utilization are phased in at 6 and 18 months respectively. Estimates for state hospital savings assume the closure of 42 beds, or approximately one and one-half hospital wards, 18 months after the teams are implemented. However, given the marginal state savings gained and significant federal funding lost, as well as current pressures on the state hospitals, one alternative would be to retain this capacity in the state hospitals, or to reduce only partially.

Anticipated Outcomes of Approach:
Using high intensity treatment teams for the most severe clients will improve the quality of life for clients as well as their families. They will reduce the time clients spend in more costly hospital care, provide clients with the supports needed to be more successful in school, alleviate family stress and conflict, and help clients build more satisfying lives with less debilitating symptoms.

Possible Disadvantages, or Implementation Barriers:
Starting up and training 18 treatment teams in a short period of time, while ensuring consistently high quality, will be an implementation challenge for the Regional Support Networks and the Mental Health Division.

Service Improvement Option #3
HIGH-INTENSITY TREATMENT FOR CHILDREN

Strategy: Develop wraparound treatment teams throughout the state to treat children with serious and persistent mental illness in a comprehensive, locally based way.

Description: This option would establish 8 staff-intensive wraparound teams in the state for children experiencing significant disabilities from mental illness. Each team carries a caseload of 30 clients, with staff to client ratios of 1:5. This model has proven highly effective for instances where a traditional outpatient approach (with staff to client ratios of 1:60) has not been successful at preventing severe acute episodes. In total, the teams would serve a caseload of 240 children at any given time.

Teams focus on: 1) lessening or eliminating those symptoms of mental illness that are debilitating to the client; 2) preventing or minimizing acute psychiatric episodes; and 3) improving social functioning and ability to succeed in school settings. This multi-faceted approach is designed to enhance the quality of life of the client and his or her family members.

Projected Net Impact in State Dollars: Cost of $1.2 million per year (3-yr average)

Cost notes: Savings due to reduced community hospital and CLIP bed utilization are phased in at 6 and 18 months respectively. Estimates for CLIP bed savings assume the closure of 16 CLIP beds 18 months after the teams are implemented. This estimate is based on Clark RSN's experience of reducing CLIP bed recidivism by 100%; however, this proposal assumes a reduction of 50%, in order to take into account unmet demand.

Anticipated Outcomes of Approach:
Using high intensity treatment teams for the most severe clients will improve the quality of life for clients as well as their families. They will reduce the time clients spend in more costly hospital care, provide clients with the supports needed to be more successful in school, alleviate family stress and conflict, and help clients build more satisfying lives with less debilitating symptoms.

Possible Disadvantages, or Implementation Barriers:
Starting up 8 treatment teams in a short period of time, while ensuring consistently high quality, will be an implementation challenge for the Regional Support Networks and the Mental Health Division.

Service Improvement Option #4
CO-OCCURRING DISORDER TREATMENTS

Strategy: Provide short- and intermediate-term stabilization and treatment in all regions of the state for adults with co-occurring mental health and chemical dependency disorders.

Description: Research consistently indicates that consumers with co-occurring disorders account for as many as 70% of the chronically mentally ill individuals served in the community mental health system. These individuals are often chronic recidivists, returning to hospital ERs, psychiatric inpatient facilities, and jails. State hospital staff indicate these patients are among the most difficult to place and that they often remain in the hospital longer than they might if better alternatives were available.

This strategy would create both outpatient and residential treatment capacity statewide. Outpatient services, provided through an average of one specialized high intensity team per Regional Support Network would provide capacity for outpatient stabilization and treatment. Teams would serve a total caseload of 1400 clients statewide.

Residential services, provided in two statewide programs, would provide higher intensity treatment. These residential facilities would be 16 beds or less and could be co-located with existing chemical dependency residential treatment programs. These facilities would serve an estimated 260 clients per year.

Participants in both the outpatient and residential programs would return to more traditional mental health and chemical dependency treatment programming for follow-up after program completion, thus creating capacity for new admissions.

Projected Net Impact in State Dollars: Cost of $3.6 million per year (3-yr average)

Cost notes: Savings due to reduced community and state hospital utilization are phased in at 6 and 18 months respectively. Estimates for state hospital savings assume the closure of 25 beds, or nearly one hospital ward, 18 months after the teams are implemented. However, given the marginal state savings gained and significant federal funding lost, as well as current pressures on the state hospitals, one alternative would be to retain this capacity in the state hospitals, or to reduce only partially.

Anticipated Outcomes of Approach:
It would not be unreasonable to expect the closure of one or more state hospital wards as a result of the implementation of this program package. It is highly likely that reductions would occur in the use of local psychiatric inpatient and E&T facilities, ERs, and jails. Integrated co-occurring disorder treatment is one of 6 SAMHSA “best practices”.

Possible Disadvantages, or Implementation Barriers:
Establishing co-occurring treatment teams requires significant culture shifts among staff and program administrators who are used to treating sequentially or in parallel. Training and program leadership will be crucial to the success of such a program.

Service Improvement Option #5
EXPAND EMPLOYMENT SERVICES

Strategy: Expand employment services to reduce gaps in currently available services.

Description: Employment services are fundamental to a recovery-oriented public mental health system. While some pre-employment and employment services are available through Medicaid, as well as through DSHS' Division of Vocational Rehabilitation (DVR), there are significant gaps in coverage, making it difficult to sustain a cohesive program that supports consumers in securing and maintaining employment.

This strategy would do the following to address existing gaps in employment services:

1) Provide increased Supported Employment services to Medicaid clients being served by DVR and/or on the waiting list for DVR. Many mental health clients on the DVR waiting list will never be served because their disability is not severe enough to meet DVR's "order of selection;"
2) Cover ongoing job development activities that are not covered by Medicaid Supported Employment;
3) Provide pre-employment and employment services for non-Medicaid clients; and
4) Contribute start-up funding for clubhouse programs that provide effective pre-employment and employment support services.

This option would provide supported employment assistance to 420 additional clients, as well as those served through two new clubhouse programs.

Projected Net Impact in State Dollars: Cost of $805,000 per year (3-yr average)

Anticipated Outcomes of Approach:
Supported Employment is one of the SAMSHA Evidence-Based Practices, with demonstrated effectiveness in:

1) Helping people obtain and retain competitive employment;
2) Addressing a top priority of people with severe mental illness and their families;
3) Reducing utilization of inpatient and outpatient mental health services; and
4) Helping people achieve recovery.

Possible Disadvantages, or Implementation Barriers:
This option requires up-front system investment, with a delayed benefit in cost savings to the system.

Service Improvement Option #6
REDUCE "IMD'S" & PROVIDE RESIDENTIAL ALTERNATIVES

Strategy: Implement a 6-year-plan to replace and/or convert residential IMDs with non-IMD facilities which can draw federal match.

Description: Medicaid match cannot be drawn down for residential facilities for 21- to 64-year-olds with more than 16 beds, due to the federal IMD exclusion. This proposal would maximize Medicaid funding without reducing the state's overall residential capacity. It would do so by replacing and converting residential IMD facilities with non-IMD facilities over a six year period.

Specifically, those IMDs with up to 28 beds would reduce capacity to 16 and be held harmless; at the same time, an equivalent number of new intensive supported housing slots would be developed, which would be eligible for Medicaid funding. Consumers who are discharged from facilities due to the conversion will be placed in these new settings and will continue to receive intensive outpatient services.

The likely candidates for the conversion are as follows.
a. Moores Boarding Home, intensive boarding home, Spokane County, 18 beds.
b. Seeley Lake Lodge, ARRC-long term care facility, Pierce County, 19 beds.
c. Sunnyside Crossroads, ARRC-long term care, Greater Columbia RSN, 25 beds.
d. Columbia River-Elahan Place, ARRC-long term care facility, Clark County, 28 beds.

While total operating costs of affected facilities are not likely to change substantially, they will be eligible to earn federal Medicaid match, which will significantly reduce the state funds required to operate the facilities.

Projected Net Impact in State Dollars: Savings of ($811,000) per year

Anticipated Outcomes of Approach:
Maximize Medicaid funding.

Possible Disadvantages, or Implementation Barriers:
Capital budget funds may be needed if new residential facilities need to be built. Implementation will require an eye to regional capacity so that the conversion does not reduce capacity in any areas to the point that the needs of consumers in that area are adversely affected. For the future, for facilities larger than 28, a cost study should be conducted to determine the breakeven point where the benefit of earning federal funds meets the disadvantage of loosing economy of scale.

Service Improvement Option #7
TWO NEW EVALUATION & TREATMENT CENTERS

Strategy: Invest this biennium in two freestanding Evaluation and Treatment Centers (E&Ts) to reduce pressure on inpatient beds and avoid future need for increases in state hospital beds.

Description: This effectiveness strategy calls for the development and ongoing sustained funding for two sixteen bed (32-bed total) new inpatient E&T facilities, to become operational in December 2005 and April 2006.

In 2002, Public Consulting Group (PCG) studied inpatient and residential services for adults served by the Mental Health Division. This study examined capacity and utilization in state hospitals, community hospitals, and E&Ts, and compared them to resources available in peer states. The report identified Washington as over-reliant on state hospital beds and recommended redirecting funding to build and develop community resources. It found that approximately 500 episodes of acute psychiatric care per year currently treated in the state hospitals could be served in community hospitals or E&Ts if beds were available.

Since the PCG Study, a recent survey by the Washington State Hospital Association has documented a 13% decrease in community inpatient beds between 2000 and 2004. The 2004 PCG Study, which updates the 2002 Study, recommends the creation of 85-90 new E&T beds statewide.

Projected Net State Costs and Savings from Implementing:

New Costs:	**Operating:**	**$4.0 million per year**
	Capital:	**$5.1 million**

(Savings): Savings would come from decreased use of inpatient beds in future biennia.

Net Operating Cost or (Savings): $4.0 million per year

Anticipated Outcomes of Approach: Establishing two new E&Ts will reduce pressure on existing overtaxed inpatient beds by providing additional capacity in the system. Current rates for freestanding E&Ts are less expensive than community inpatient beds and help consumers to maintain their connections to family and community supports by permitting them to remain in their communities for short term detentions. In addition, the additional capacity will help to reduce penalties on RSNs that exceed their allocation of state hospital beds and RSN retention of these funds can be used to provide community supports that might prevent hospitalizations.

Possible Disadvantages or Implementation Barriers:

Site selection and the methodology for contracting funds will provide challenges in implementing this strategy. DSHS must determine whether these facilities will provide statewide access or be restricted to residents from the RSN in which the facilities are located. In addition, the timeframes for such projects may be delayed for many reasons.

Service Improvement Option #8
DEVELOP MENTAL HEALTH CRISIS DIVERSION BEDS

Strategy: Add thirty-four more community based hospital diversion beds to the continuum of care in order to increase the emergency availability of existing community and state hospital beds for involuntary treatment.

Description: Hospital diversion beds are beds in less intensive settings than hospital beds and are structured for short term use to stabilize a crisis or provide a form of respite in situations that would otherwise escalate into necessary hospitalization or possible detention under the involuntary treatment act. Increasing the number of diversion beds will alleviate some of the demand for existing inpatient psychiatric beds.

The current statewide crisis in the availability of involuntary treatment beds has been deepening. It is precipitated by increases in state population, changes in state hospital admission criteria, increases in overall involuntary detentions, and a 13% decrease in community inpatient psychiatric beds from 2000 to 2004. The lack of available beds has resulted in incidents of detention to non-psychiatric beds such as emergency rooms, medical floors and "one bed certifications" in general hospitals. Available data indicates that there are from 2-25 admissions per month to non-mental health beds and wait times for any appropriate bed can be as high as 96 hours.

Projected Net State Costs and Savings from Implementing:

New Costs: **$1.6 million per year**

(Savings): Savings would come from decreased use of inpatient beds in future biennia.

Net Cost or (Savings): **$1.6 million per year**

Anticipated Outcomes of Approach:
Implementing and funding this service option will improve the availability of existing hospital, E&T and state psychiatric beds needed for emergency involuntary detentions. This option along with other system changes and additions can improve the bed availability without adding new hospital beds. Cost savings can be realized in future biennia as this lower cost diversion beds are used in lieu of hospitalization.

Possible Disadvantages, or Implementation Barriers:
Diversion bed admissions will need to be restricted to very short stays to assure the continued availability of these beds as an emergency resource and will need to be distinguished from crisis respite beds, with access controlled through an established gatekeeper, such as Crisis and Commitment offices. Appropriate use of this option will not always prevent or shorten inpatient hospital stays. To be most effective, diversion beds must be developed to accommodate the complex needs of populations that use a high percentage of inpatient hospital days. Population examples include mentally ill persons with developmental disability, geriatric, and substance disorder treatment needs. Treatment examples include medical assessment, intervention, and 1:1 staffing.

Service Improvement Option #9
IMPROVE UTILIZATION OF HIGH COST RESIDENTIAL CARE

Strategy: Review current residents in residential treatment settings and assertively transfer those persons who can be appropriately served in less expensive and more independent settings to facilitate each person's recovery while minimizing system costs.

Description: Adult Residential Rehabilitation Centers (ARRCs) and intensive boarding home programs are expensive because they provide high professional expertise and staffing ratios, client monitoring, substantial daily structure, and complex medical and psychiatric medication regimens for residents. These placements are most effective when careful triage ensures that persons with the highest intensity needs are selected. Some consumers need high intensity residential settings for many years and should not be destabilized by wrong moves. This strategy must not become a blanket time limit.

Improving the utilization of ARRCs and intensive boarding homes requires careful review of current residents, assertive planning to move those appropriate for less intensive settings, establishment of more supported housing in the community, and careful screening of future candidates. Careful and coordinated transition planning can move appropriate new residents into ARRCs and intensive boarding homes from even more expensive inpatient, institutional, or crisis settings. Appropriate housing needs to be in place for those consumers moved out of ARRCs and intensive boarding homes. Careful transitions to these more independent settings can be very successful, but a lack of planning or services may result instead in persons recycling back through more expensive inpatient facilities and back into ARRCs.

Projected Net State Costs and Savings from Implementing:

New Costs: **$103,000 per year**

(Savings): Until there is sufficient bed capacity to meet demand, savings cannot be assumed from this measure. However, pressure on ITA beds may be alleviated because more high risk consumers will be receiving an appropriate level of care. Avoided hospitalization and incarceration costs may also provide savings, though this will be difficult to measure.

Net Costs or (Savings): **$103,000 per year**

Anticipated Outcomes of Approach:
Because there is a substantial waiting list for ARRC beds, there would be no reduction in the number of persons served or ARRC beds needed. The persons placed in ARRCs would be, on average, more acute in symptoms and challenges. Persons in ARRCs would be in the least expensive alternative that was medically appropriate. Those moved to less intensive setting would achieve more independence, step toward recovery, and have a reduced cost of care.

Possible Disadvantages, or Implementation Barriers: These changes will challenge the belief of some providers. DSHS and the RSNs must encourage CTED and local governments to target housing development funds for secure housing for persons with mental illnesses so that persons leaving ARRCs will have housing.

Service Improvement Option #10
COMPREHENSIVE PLAN FOR RESIDENTIAL/INPATIENT SERVICES

Strategy: Create a comprehensive plan to transform the system from dependence on state hospitals to predominance of community-based care.

Description: A comprehensive plan will provide a clear statewide roadmap to transform our system's current dependence on state hospitals to a truly community-based system and orchestrate this change. The plan and attending process would:

- Address gaps in the community-based care system, costs, funding sources, allocation of resources, and define the steps that must occur
- Integrate the products of current activities such as PCG recommendations and Cross System Crisis Response recommendations into a single plan
- Consolidate state, regional and local activities into a single plan
- Furnish the necessary national expertise
- Provide professional facilitation for the process
- Provide focus on the implementation steps to bring about steady, forward progress
- Minimize fragmentation in approaches

Projected Net State Costs and Savings from Implementing:

New Costs: **One-time costs of $104,000**

(Savings): If this plan is successful, long-term savings will result from a system designed to allow individuals to receive care in the lowest cost setting that is appropriate to meet their treatment needs.

Net Cost or (Savings): **One-time costs of $104,000**

Anticipated Outcomes of Approach:
A statewide plan will increase the likelihood of successfully shifting system philosophy, utilization service models, and resources from state hospitals to community-based services. It will reduce fragmentation of activities, increase consolidation of effort, and provide a clear and unified understanding of the goal and the steps to reach it. The plan itself will be more effective if done with expert technical assistance.

Possible Disadvantages, or Implementation Barriers:
System change of this magnitude would be very hard to do adequately without expert advice and planning and without professional facilitation to assist the stakeholders to come to agreement and complete implementation. While the initial cost might appear to be less without bringing in expert assistance, the lack of appropriate resources could defeat the purpose. The expertise does not reside within the system's immediate ranks and must be brought from outside.

Service Improvement Option #11
CHILDREN'S THERAPEUTIC FOSTER CARE

Strategy: Develop and implement the evidence based practice of therapeutic foster care models throughout the state to serve high risk children and adolescents.

Description: This option targets children with mental health issues who need intensive therapeutic interventions. It would allow them to remain in the community or, if in a Children's Long-Term Inpatient Program (CLIP) placement, to transition successfully back to their parents or other permanent placement. This will allow communities with few options to divert children from the more expensive or community hospital stays.

Currently, CLIP is one of the very few resources available for children with mental health needs. CLIP beds often have a waiting list. Consequently children may be either left waiting in community hospitals or be discharged without the type of care needed to allow them to transition safely back into the community. The option will create at least three new therapeutic foster care models. It will use the Oregon Social Learning Model in western Washington. This model requires a cluster of ten or more foster homes and is most appropriate in more dense, urban areas. In more rural areas, a different therapeutic foster care model may be needed, and models developed by Mentor, Inc. and Pressley Ridge should be considered.

Initially, some new capacity would be reserved to facilitate timely and therapeutically effective transition from CLIPs. Each program should be "teamed" with specific CLIP facilities. As a therapeutic foster care option becomes more widely available, the option will provide direct access for minors who would otherwise require admission to a CLIP facility or have extended community hospital stays.

Projected Net General Fund State Costs (Savings): $0.9 Million per year

Cost notes: Costs were based on $160/day per bed and include program coordinator, training and project analysis costs. The model allowed for only 25% federal funding.

Anticipated Outcomes of Approach: This option will provide a missing service in the continuum of care, reduce strain on CLIP and hospital resources, and provide a more community based approach to treatment at the level most appropriate to the monor's needs. It will also provide support and therapy after completion of more structured treatment, reduce the number of children shifted between treatment programs, reduce runaway behavior, and decrease inappropriate juvenile justice interventions. It will improve the quality of life for minors and their families by providing treatment in the child's community. Without this, the shortage of children's resources will continue.

Possible Disadvantages, or Implementation Barriers:
Start and training for evidence based practice models of therapeutic foster care in a short period of time, while ensuring consistently high quality, will be an implementation challenge for the Mental Health Division.

Service Improvement Option #12
FORENSIC SERVICES

Strategy: Develop an additional forensic ward at the Center for Forensic Services (CFS) and add staff at Eastern State Hospital (ESH) and CFS for outpatient criminal competency evaluations.

Description: This option will meet the growing demand for forensic inpatient hospital services and reduce unnecessary admissions. The combination of additional staff for outpatient evaluations and new beds for inpatient admissions will allow CFS and ESH to keep up with court-ordered competency evaluations and restorations and reduce the waiting lists to within constitutional limits at both facilities.

Under the Constitution, a person must be competent to stand trial for a crime. If an incompetent person's competency cannot be restored, the case must be dismissed. Demand for competency evaluation and restoration is increasing. The CFS inpatient waiting list has grown dramatically, peaking in February 2004 at 77 persons, with a 2004 daily average of 48.1 persons. On average, a defendant must wait 32 days for an inpatient competency evaluation. Court ordered 90-day competency restorations "crowd out" or delay admission of lower priority cases. CFS has difficulty meeting the legal requirement to admit restoration cases within seven days. Courts have issued show cause orders and threatened the state with contempt and dismissal of cases for failure to meet legal requirements for timely evaluation and restoration. The delays for competency evaluation and restoration also add to the overcrowding of the state's jails.

While some defendants require inpatient evaluation, in most cases, the faster turnaround for outpatient evaluations makes them an attractive alternative to committing the defendants to CFS or ESH. Currently, CFS and ESH are the state's only competency restoration providers and restoration requires inpatient treatment.

Projected Net General Fund State Costs (Savings): $4.0 Million per year

Anticipated Outcomes of Approach: This option will expedite both competency evaluations and restoration, thereby significantly reducing the waiting list for forensic inpatient admissions, bringing CFS and ESH within constitutional limits. It will provide due process for mentally ill defendants, improve the care and management of these persons, increase public safety, and provide reliable and useful identification of mentally ill offenders. It will also eliminate the threat of show cause or contempt hearings against the state and the dismissal of criminal cases due to delays at CFS and ESH.

Possible Disadvantages, or Implementation Barriers:
Starting up and hiring additional staff on a condensed time line, while ensuring consistently high quality, presents implementation challenges for CFS, ESH and the Mental Health Division.

Service Improvement Option #13
COMMUNITY PSYCHIATRIC HOSPITAL RATE INCREASE

Strategy: Increase rates for community psychiatric hospitals to ensure no more loss in beds available to serve those clients in need of hospitalization.

Description: At a time when the state is short of community hospital beds and is reducing state hospital beds, the state has lost 95 community inpatient beds for public clients over the last two years. Rate increases utilizing RSNs funds have been insufficient to keep community hospitals in providing beds for public assistance clients. Many hospitals have expressed their concerns over the low reimbursement rates paid for mentally ill individuals on Medicaid and other public assistance programs. Psychiatric wards have never been profitable ventures for most hospitals, but some could cover the shortfalls with revenue from their medical/surgical units. Unfortunately, the growing cost of medical care has made this situation even worse. Many hospitals are cutting beds and threatening to close psychiatric units without a more appropriate reimbursement rate.

Community inpatient psychiatric care in an essential part of the continuum of care. Although hospitalization is and should be a last resort, there are times when inpatient treatment is medically necessary to keep the individual and the community safe. Without community inpatient capacity the need for state hospital beds increases. As medical costs continue to increase, the state's reimbursement rates must also be increased or the mental health system will find itself even less ability to treat individuals needing acute care.

Projected Net General Fund State Costs (Savings): $4.6 million per year

Cost notes: The yearly cost reflects moving hospital rates for non-medicaid clients' community hospital care to the Medicaid rate.

Anticipated Outcomes of Approach: Adequate reimbursement will allow many community hospitals to remain open decreasing the need for state hospital beds

Possible Disadvantages, or Implementation Barriers: Medical costs will continue to rise, therefore, additional increases will be necessary in the future.

Service Improvement Option #14

Aging & Disability Services Diversion Beds

Strategy: Create community-based diversion beds and intensive case management for persons whose medical/mental health/behaviors exceed under current licensing regulations in order to stabilize and divert these persons from institutionalization in correctional facilities or the state hospitals.

Description: There are several categories of persons whose disorders make them eligible for mental health treatment but who, because of medical needs, behavioral issues created by their mental disorder, or history of past behaviors, have either failed in residential settings or are unable to access services in facilities under the current licensing structures. These populations have high needs and often are referred to CDMHPs for involuntary commitment. Because CDMHPs do not have secure treatment facilities in which to detain these persons, they may remain in the community without treatment, seek treatment in hospital emergency rooms, or be placed in jails or prisons. Although these persons may not need the level of acute care at the state hospital, they need either more secure facilities than those that exist under current skilled nursing and residential licenses or they have failed in these facilities in the past.

This Service Improvement Option would establish, license, inspect and enforce regulations of enhanced services facilities which would do the following:

- Divert persons from unnecessary institutionalization in state hospitals or correctional facilities, and do so at lower costs
- Ensure appropriate treatment for the person's disorder or disorders
- Provide intensive case management

Federal changes have indicated that the use of state hospital beds for these populations will be a state-only cost at any time that these persons do not meet the medical necessity standards for acute inpatient treatment. In addition,

Projected Net General Fund State Costs (Savings): $4.9 million per year

Cost notes: These are new operating costs. Over time, savings are from reductions in need for state hospital beds, court proceedings, and correctional incarcerations.

Anticipated Outcomes of Approach: This would provide appropriate treatment options in secure facilities for these complex clients, reduce the use of state hospital, jail, and prison beds.

Possible Disadvantages, or Implementation Barriers: These are a new kind of licensure that will require new statutory authorization and development of WACs. Facilities treating adults under 65 years of age would need to be limited to 16 beds to avoid potential determination as an IMD. There will need to be some education for persons involved in the commitment process to clarify that commitment to these facilities is permitted.

Service Improvement Option #15

Integrated Crisis Response System (2 Pilots)

Strategy: Provide a combined mental health and chemical dependency crisis response including two pilot projects, two secure detoxification facilities, and an evaluation of the pilots.

Description: . Under the combined crisis response pilots, up to 25 CDMHPs would be trained and up to 5 would be hired to implement a combined mental health and chemical dependency crisis response and detention process. These designated crisis responders would have statutory authority to detain persons to either a mental health facility or a secure detoxification facility using the involuntary treatment detention process.

This implements, on a pilot basis, one recommendation of the Cross-Systems Crisis Response Task Force (CSCR). The CSCR was a task force jointly convened by DSHS and the counties with participation from all groups participating in or affected by crisis response services. The CSCR found that the public mental health system serves as the default crisis response and involuntary commitment system for persons with a wide range of emotional and behavioral issues. It made recommendations to create efficiencies for crisis responders, develop targeted diversion and detention options, and other appropriate resources to minimize the inappropriate use of costly hospital settings.

Currently, there are not secure detoxification settings for two populations: chemically dependent persons who need to be detoxified but who are combative or for other reasons cannot be placed in existing facilities because they are not secure; and those who, having been detained for 72 hours, are still too unstable to be released. Currently, these persons may be detained in inpatient psychiatric facilities without receiving needed chemical dependency treatment. This puts unnecessary pressure on an overtaxed resource and leads to individuals “recycling” through the system.

Projected Net General Fund State Costs (Savings): $4.2 million per year

Cost notes: These are new operating costs for two pilot sites and two secure detox facilities with an evaluation component to determine cost effectiveness.

Anticipated Outcomes of Approach: These pilots, one in an urban and one in a rural or suburban setting would provide a combined crisis response with the statutory authority to detain to the appropriate facility. They would be evaluated to ensure that the combined response resulted in more appropriate placements and were cost effective prior to requesting statewide implementation.

Possible Disadvantages, or Implementation Barriers: There may be providers and crisis responders who resist a coordinated or simultaneous response to both mental health and chemical dependency treatment needs. Siting the secure detoxification facilities may face community resistance that neither DSHS nor the RSN can control.

Service Improvement Option #16
ADDITIONAL COMMUNITY RESIDENTIAL BEDS

Strategy: Develop 100 new residential treatment beds to increase the capacity of the community system and meet identified gaps in community based residential services.

Description: The capacity study conducted by the Public Consulting Group strongly suggests that the existing provider network has insufficient residential capacity to meet the current level of demand. This results in the disruption of the smooth patient flow through the entire continuum of care. The PCG study recommends the addition of 408 community mental health residential beds.

The lack of residential capacity prevents hospitals from discharging patients to more appropriate settings in a timely manner. This results in longer lengths of stays, fewer new admissions (exacerbated by state hospital waiting lists and admission delays) further reducing access to care and higher than necessary treatment costs. This lack of capacity essentially "backs up" the entire system, forcing higher inpatient providers to serve patient populations that they are not best suited to manage or that do not require hospital level of care. Discharge delays due to lack of residential capacity can prevent timely civil commitment of persons to inpatient psychiatric beds, sometimes resulting in long stays in emergency rooms because there are no beds available. This problem also disrupts overall system quality and cost effectiveness through the ineffective alignment of patient care needs with the provider who best can provide the service.

Projected Net General Fund State Costs (Savings): $3.1 Million per year

Cost notes: This is an initial down payment on the 408 recommended beds in the Public Consulting Group Study at $125 day. This assumes an average one-third federal match for ARRCs.

Anticipated Outcomes of Approach: This will allow state hospitals to better focus on those psychiatric populations that cannot be treated in the community, provide increased state hospital capacity to accept appropriate, medically necessary admissions from community hospitals and E&Ts, reduce any excess state hospital capacity. Realized cost savings will provide funds to reinvest in community based services and lower cost programs designed to meet the clinical needs of the patients, while protecting the community at large. Potentially this option will reduce admissions to the state hospitals and increase appropriate, cost-effective treatment provided in the community.

Possible Disadvantages, or Implementation Barriers:
Capital budget funds may be required if new residential facilities must be constructed. Implementation requires an eye to regional capacity so that the development of additional residential beds is regionalized where the greatest needs are. Establishing additional residential beds requires up-front system investment.